DOES NOT CIRCULATE

CLINICAL MEDICINE

UNIVERSITY
OF MICHIGAN
JAN 22 1953
MEDICAL
LIBRARY

Rural Medical Care
Retroversions of Uterus
Culdoscopy
Postcholecystectomy Syndrome
Vitamin E
Skin Grafting
Vaginal Thrush
Aids in Diagnosis
Therapeutic Trends
Literature Service

JANUARY 1953

VOLUME 60, NUMBER 1

General Library
Ann Arbor, Mich.
0254

Medical Library
610.5
C64
M5
v.60

New! *High Potency Anticholinergic Agent*

Antrenyl™

BROMIDE

(Oxyphenonium bromide Ciba)

Mg. per mg., the most effective of the newer anticholinergics

ANTRENYL bromide is a new high potency anticholinergic agent indicated in the management of peptic ulcer and spasm of the gastrointestinal tract. Milligram per milligram, it is the most potent of the newer anticholinergics, recommended dosage being only about *one-tenth* that of certain commonly used agents.

ANTRENYL has a marked inhibitory effect on gastric secretion and motility of the gastrointestinal tract. Side effects are generally mild, and there is usually no esophageal or gastric irritation. A recent report[1] described the side effects as less pronounced than those of other drugs ordinarily used in the management of peptic ulcer.

In this study, patients receiving ANTRENYL usually obtained relief from acute symptoms within 24 to 36 hours.

Prescribe ANTRENYL as adjunctive therapy in your next few cases of peptic ulcer and note its advantages.

Available as ANTRENYL Bromide Tablets, 5 mg., scored: bottles of 100, and as ANTRENYL Bromide Syrup, 5 mg. per teaspoonful (4 cc.); bottles of 1 pint.

Ciba

Ciba Pharmaceutical Products, Inc., Summit, New Jersey

2/10700

1. Rogers, M. P., and Gray, C. L.; *Am. J. Digest. Dis.*, 19:180, 1952.

CLINICAL MEDICINE

Established 1894

Published Monthly, $5.00 Per Year

FREDERIC R. STEARNS, M.D., *Editor*

WALTER THIELE, *Editorial Assistant*

EDITORIAL BOARD

LYNN D. ABERNETHY, M.D.
Ophthalmology

W. S. ANDERSON, EM. PROF.
Medical Genetics

G. C. ARNOLD, M.D.
Audiology and Phonology

JULIUS BAUER, M.D.
Internal Medicine

ERIC BELL, M.D.
Neurology and Psychiatry

EUGENE BERESTON, M.D.
Dermatology and Syphilology

SEYMOUR BROWN, M.D.
Anesthesiology

LEON C. CHESLEY, PH.D.
Physiological Chemistry

JOHN A. CONLEY, M.D.
General Practice

C. D. CREEVY, M.D.
Urology

HOWARD E. CURL, M.D.
Radiology

LEWIS DANZIGER, M.D.
Neurology and Psychiatry

NATHAN S. DAVIS, M.D.
Internal Medicine

F. LOWELL DUNN, M.D.
Internal Medicine

BENJAMIN ESTERMAN, M.D.
Ophthalmology

EVERETT C. FOX, M.D.
Dermatology and Syphilology

HARRISON C. HARLIN, M.D.
Urology

EDGAR A. HAUNZ, M.D.
Internal Medicine

F. A. HELLEBRANDT, M.D.
Physical Medicine, Rehabilitation

ELMER HESS, M.D.
Urology

FELIX A. HUGHES, JR., M.D.
Surgery

ARNOLD H. JANZEN, M.D.
Radiology

S. R. KAGAN, M.D.
History of Medicine

FRANZ KALLMANN, M.D.
Medical Genetics

KARL J. KARNAKY, M.D.
Gynecology and Obstetrics

BORRIS A. KORNBLITH, M.D.
Surgery

IAN MACDONALD, M.D.
Oncology

MADGE T. MACKLIN, M.D.
Internal Medicine

BENJAMIN MALZBERG, PH.D.
Medical Statistics

JOHN R. McCAIN, M.D.
Gynecology and Obstetrics

FREDERIC E. MOHS, M.D.
Surgery

GARRETT PIPKIN, M.D.
Surgery

R. A. ROSS, M.D.
Gynecology and Obstetrics

MAURICE SALTZMAN, M.D.
Oto-Rhino-Laryngology

S. R. SNODGRASS, M.D.
Surgery

ARTHUR STEINHAUS, PH.D.
Physiology

HAROLD SWANBERG, M.D.
Radiology

WILSON A. SWANKER, M.D.
Plastic Surgery

LUDWIG TELEKY, M.D.
Industrial Medicine

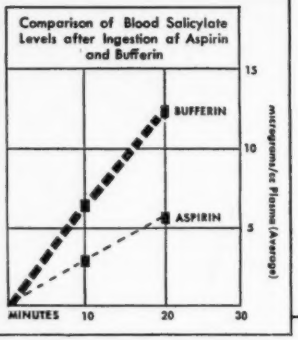
JOSE ZOZAYA, M.D.
Internal Medicine

CLINICAL MEDICINE, published monthly by the American Journal of Clinical Medicine, Inc., at Wilmette, Illinois. Title registered in U.S. Patent Office. Entered as second class matter August 1, 1942, at the Post Office at Wilmette, Illinois, under Act of March 3, 1879. SUBSCRIPTION PRICES, United States and possessions and Canada, 1 year $5.00, 2 years $8.00, 3 years $10.00. Other countries add .50 yearly additional charge. Remit by money order or draft on United States Bank. Single copy .50. Printed in U.S.A. Address all correspondence to Publication Office, Wilmette, Illinois.

Faster Pain Relief with BUFFERIN®

1 ACTS TWICE AS FAST AS ASPIRIN

The antacids in Bufferin speed its pain-relieving ingredients through the stomach and into the blood stream. Actual chemical determinations show that within ten minutes after Bufferin is ingested blood salicylate levels are higher than those attained by aspirin in twice this time.[1]



2 DOES NOT UPSET THE STOMACH

Bufferin's antacid ingredients protect the stomach against aspirin irritation. This has been clinically demonstrated on hundreds of patients.

in usual doses

In a series of 238 cases, 22 had a history of gastric distress due to aspirin but only one reported any distress after taking 2 Bufferin tablets (equivalent to 10 grains of aspirin).[1]

in large doses

In a recent study group, 1006 patients received, over a 24 hour period, 12 Bufferin tablets (equivalent to 60 grains of aspirin). Although 72 had a history of being sensitive to aspirin, only 18 reported any gastric side-effect with Bufferin.[2]

1. Effect of Buffering Agents on Absorption of Acetylsalicylic Acid. J. Am. Pharm. Assoc., Sc. Ed. 39:21, Jan. 1950
2. Gastric Tolerance for Aspirin and Buffered Aspirin. Ind. Med. 20:480, Oct. 1951

AVAILABLE in vials of 12 and 36 tablets and in bottles of 100. Tablets scored for divided dosages.

INDICATIONS. Simple headaches, neuralgias, dysmenorrhea, muscular aches and pains, discomfort of colds and minor injuries. Particularly useful when gastric hyperacidity is a complication. Useful for relieving pain in the treatment of arthritis.

EACH BUFFERIN TABLET contains 5 grains of acetylsalicylic acid, together with optimum amounts of the antacids aluminum glycinate and magnesium carbonate.

Bristol-Myers Co., 19 West 50 St., New York 20, N. Y.

Medical.

TABLE of CONTENTS

60th year of publication

Vol. 60, No. 1 January, 1953

EDITORIAL

Improving Rural Medical Care 15
H. B. Mulholland, M.D.

ORIGINAL ARTICLES

Management of Retroversions and Retroflexions of the Uterus in General Practice 19
John R. McClain, M.D.

Culdoscopy 25
Donald C. Schweizer, M.D.

Postcholecystectomy Syndrome 30
G. B. Hodge, M.D.

Vitamin E in Treatment of Diseases of the Skin . . . 31
Marcus T. Block, M.D.

Skin Grafting as an Office Procedure 35
Wilson A. Swanker, M.D.

Scientific Exhibit 38

Therapeutic Trends 40

Aids in Diagnosis 43

Send for This Literature 46

New Pharmaceutical Products 49

Contributions of papers for publication in Clinical Medicine should be addressed to The Editor, Clinical Medicine, Wilmette, Illinois.

Manuscripts should be typed double or triple-spaced, on one side of the paper only. Drawings or photographs will be reproduced at no cost to the author. Bibliographic references should be kept to a minimum, and, if included, should be as complete as possible. Manuscripts, when accepted, become the property of Clinical Medicine.

BLAKISTON
the
MEDICAL
AND SCIENCE
PUBLISHERS

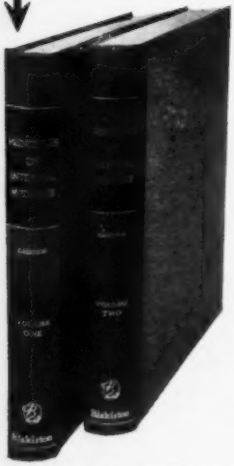
The Book That HELPS YOU To Recognize, Treat and Understand Common Disorders Faster and More Accurately

HARRISON'S Principles of Internal Medicine

Edited by: T. R. Harrison, M.D.,
M. M. Wintrobe, M.D., Paul B. Beeson, M.D.,
William H. Resnik, M.D., George W. Thorn, M.D.

Most Authoritative Book In Its Field

Emphasizes The Functional Approach To Specific Disease Treatment. VOLUME I discusses the manifestations and mechanisms of diseases with their physiologic considerations. This volume includes reactions to stress and to antigenic substances as well as a discussion of metabolic and endocrine disorders. VOLUME II contains the specific disease material and discusses: disorders due to chemical and physical agents—diseases due to biologic agents—and diseases of organ systems. Illustrative roentgenograms and photographs. *Double column pages for easy reading. Large modern typography for extra legibility. Non-gloss paper to eliminate eye strain.*



HARRISON'S Principles of Internal Medicine
In The Easy-to-Use Two Volume Set $18.00
In One Volume.....$15.00

ORDER HERE

THE BLAKISTON COMPANY, INC.

575 Madison Avenue
New York 22, N.Y.

105 Bond Street
Toronto 2, Canada

Please send me HARRISON'S Principles of Internal Medicine, Two Vol. Set.....$18 ☐
In One Vol.....$15 ☐

☐ Check or M.O. Enclosed ☐ Charge ☐ Send C.O.D.

Name_____

Address_____

City_____ Zone____ State_____

CM 1-53

EDITORIAL

Improving Rural Medical Care

H. B. MULHOLLAND, M.D., *Member, Council on Rural Health, American Medical Association, Charlottesville, Virginia*

Some seven years ago farm people were showing great concern over the apparent lack of adequate medical care for the rural population. Forty years ago, there were many more doctors practicing in small communities than there are today. Why, asked these groups, is this so and why isn't something done about it? Quoting such statistics, some groups have actually accused the American Medical Association of plotting to hold down the number of medical graduates in order to maintain their own selfish interests. Only one week ago, in discussing medical care problems, one of my students quoted a history professor in a nearby college as subscribing to this fallacy. Little do they know that many of these doctors forty years ago were graduates of second and third class medical schools, and that now, due to modern methods of transportation and amazing advances in diagnosis and treatment, one doctor can do the work of four or five who practiced in that era.

Those who should be most concerned, the doctors, heard these rumblings and proceeded to search for the facts and truth in this situation. Two rural neighbors, one a doctor, F. S. Crockett, and Mrs. C. W. Sewall, that beloved Grand Dame of the Farm Bureau, got their heads together and from their cogitations a conference was arranged, the first Rural Conference between represent-

Doctor Mulholland's paper originally appeared in the *Nebraska State Medical Journal* (37:395, Dec. 1952). The subject is not only timely but so well presented that we received special permission to reprint an abridgment of the paper as an editorial.

atives of various Farm Groups and the American Medical Association. From this seed grew the Committee on Rural Health, now deservedly dignified by the cognomen of Council on Rural Health. An advisory group of lay representatives from these farm groups met with a group from the American Medical Association to plan future meetings for the full discussion of their mutual problems. At first, discussions centered around fact finding regarding the true situation, and an analysis of the real needs for medical care in rural communities. From the beginning it was obvious that the medical needs of our friends living in small communities constituted a fundamental concern in this land of ours where many citizens reside in areas with less than 2,000 population. Many states have as high as sixty-five per cent of their population in such a category. Furthermore, it was apparent from the start that no one solution could be fitted to the whole country. Each area presented its own peculiar topographical and economic differences.

So far, seven National Conferences have moved about so that each section of the country might benefit by the discussions of leaders in lay farm circles and medical groups, held in their midst, drawing into the meetings those individuals best qualified to tell us the story of that area. These frank discussions freely indulged in by both groups have resulted in educating both the doctors and their farm friends to recognize their mutual responsibilities in arriving at a solution of the problem. A physician can have the ability and facilities to deliver the best of medical care, but it may be of little effect if the farmer does not see its full value and recognize his need for these services.

A national organization, such as the American Medical Association, with the Council on Rural Health functioning as its representative in this area, is only as strong as its component groups in the various states and communities. Without their full co-operation, effort from headquarters will accomplish little or nothing. Therefore, the Council has spent much of its energy and effort in stimulating state and local medical societies to grapple with the problem, locally. By the same token, our friends the farmers must develop their own local organizations who will cooperate with medical people. Such a unit is properly named a health council, a group whose exact function is hard to define. It should encompass and encourage membership by any local group, or even individuals, interested or concerned with the health and medical care of their community. In cooperation with the Council on Medical Service, this type of organization has been urged and advised as a sine qua non in sparking local interest and action. They should be initiated by medical societies.

Our National meetings have brought out many concrete examples of actual accomplishment in various communities and states, looking toward betterment of care in rural areas.

Recently, health educators have entered the field through their association with extension bureaus of agricultural colleges, and we have brought them into our councils. These specially trained individuals with their close association with farm groups have the potentiality of doing much to carry the gospel of good health, hygiene, good nutrition, sanitation and preventive medicine, every one of which plays an important part in their message.

Of course, we are concerned with having an adequate number of doc-

tors to supply any area needing medical services. Just as in the rural population in general, there has been, in the past, a movement of doctors into urban centers. Reasons for this are obvious. The fundamental reasons are economic and social. Good roads, good schools and churches, are of importance. Good roads, especially, have made it so that a doctor can serve a much larger area.

A survey, too, may show that an area which, on a map, appears to be lacking in physicians may be adequately served by doctors on the periphery. There is a great need for good surveys which will get at the facts and show whether a doctor is really needed. One may find that the community is too small to support a physician and that the area must be served by a medical service center, where public health facilities, a few beds, laboratory and minimal x-ray facilities are constructed for use of several doctors, who pool their abilities and resources. Such centres are now being set up in a few areas under the Hill-Burton Act and, in my opinion, are more suitable for many small communities that a fifty bed hospital. Many such areas cannot support a hospital, but they can support the less expensive medical service centre, especially since the expense of health activities are in part borne by the state.

The American Medical Association, through its Council on Rural Health and Council on Medical Service, is now actively helping the states and physicians in their placement plans. Recently a meeting of states having good working plans was held in Chicago.

Recognizing the inability of our national organization to dig down to the roots of the rural problem, the Council was fortunate in securing the services of Audrey Gates, a nationally known figure in the farm world, who enjoys the respect and confidence of these people. He has visited nearly every state in the Union at least once, discussing their local problems, giving sage advice, and getting doctors and farm people together.

As in urban areas, the care of the indigent looms large in any future plan. An analysis of all types of plans existing in this country is being made by a Committee of the Council on Medical Service. There are not too many, but each one contributes something worthwhile. We hope this will help in fitting a plan to your local needs, as well as stimulating interest in the problem in general.

Chronic illness and care of the aged, ever increasing problems, dip deeply into the rural areas. All of these are receiving special study and attention. We must not overlook the necessity of fitting them into our overall plans for looking after rural groups.

It is possible only to touch lightly upon the many aspects of rural medical needs, but we must not forget such diseases common to animals and man, as brucellosis, which annually causes so much loss to the farmer and results in chronic illness and economic loss to the population as a whole. Doctors, farmers, veterinarians and the government must work together towards a solution of such problems. Why not attack brucellosis with the same vigor as that used in eradicating bovine tuberculosis as a menace?

The Woman's Auxiliary can contact the farm women, and even become members of their organizations. In this way they may help educate these people about medical care and help them solve the worst of the medical problems in their rural communities.

atives of various Farm Groups and the American Medical Association. From this seed grew the Committee on Rural Health, now deservedly dignified by the cognomen of Council on Rural Health. An advisory group of lay representatives from these farm groups met with a group from the American Medical Association to plan future meetings for the full discussion of their mutual problems. At first, discussions centered around fact finding regarding the true situation, and an analysis of the real needs for medical care in rural communities. From the beginning it was obvious that the medical needs of our friends living in small communities constituted a fundamental concern in this land of ours where many citizens reside in areas with less than 2,000 population. Many states have as high as sixty-five per cent of their population in such a category. Furthermore, it was apparent from the start that no one solution could be fitted to the whole country. Each area presented its own peculiar topographical and economic differences.

So far, seven National Conferences have moved about so that each section of the country might benefit by the discussions of leaders in lay farm circles and medical groups, held in their midst, drawing into the meetings those individuals best qualified to tell us the story of that area. These frank discussions freely indulged in by both groups have resulted in educating both the doctors and their farm friends to recognize their mutual responsibilities in arriving at a solution of the problem. A physician can have the ability and facilities to deliver the best of medical care, but it may be of little effect if the farmer does not see its full value and recognize his need for these services.

A national organization, such as the American Medical Association, with the Council on Rural Health functioning as its representative in this area, is only as strong as its component groups in the various states and communities. Without their full co-operation, effort from headquarters will accomplish little or nothing. Therefore, the Council has spent much of its energy and effort in stimulating state and local medical societies to grapple with the problem, locally. By the same token, our friends the farmers must develop their own local organizations who will cooperate with medical people. Such a unit is properly named a health council, a group whose exact function is hard to define. It should encompass and encourage membership by any local group, or even individuals, interested or concerned with the health and medical care of their community. In cooperation with the Council on Medical Service, this type of organization has been urged and advised as a sine qua non in sparking local interest and action. They should be initiated by medical societies.

Our National meetings have brought out many concrete examples of actual accomplishment in various communities and states, looking toward betterment of care in rural areas.

Recently, health educators have entered the field through their association with extension bureaus of agricultural colleges, and we have brought them into our councils. These specially trained individuals with their close association with farm groups have the potentiality of doing much to carry the gospel of good health, hygiene, good nutrition, sanitation and preventive medicine, every one of which plays an important part in their message.

Of course, we are concerned with having an adequate number of doc-

tors to supply any area needing medical services. Just as in the rural population in general, there has been, in the past, a movement of doctors into urban centers. Reasons for this are obvious. The fundamental reasons are economic and social. Good roads, good schools and churches, are of importance. Good roads, especially, have made it so that a doctor can serve a much larger area.

A survey, too, may show that an area which, on a map, appears to be lacking in physicians may be adequately served by doctors on the periphery. There is a great need for good surveys which will get at the facts and show whether a doctor is really needed. One may find that the community is too small to support a physician and that the area must be served by a medical service center, where public health facilities, a few beds, laboratory and minimal x-ray facilities are constructed for use of several doctors, who pool their abilities and resources. Such centres are now being set up in a few areas under the Hill-Burton Act and, in my opinion, are more suitable for many small communities that a fifty bed hospital. Many such areas cannot support a hospital, but they can support the less expensive medical service centre, especially since the expense of health activities are in part borne by the state.

The American Medical Association, through its Council on Rural Health and Council on Medical Service, is now actively helping the states and physicians in their placement plans. Recently a meeting of states having good working plans was held in Chicago.

Recognizing the inability of our national organization to dig down to the roots of the rural problem, the Council was fortunate in securing the services of Audrey Gates, a nationally known figure in the farm world, who enjoys the respect and confidence of these people. He has visited nearly every state in the Union at least once, discussing their local problems, giving sage advice, and getting doctors and farm people together.

As in urban areas, the care of the indigent looms large in any future plan. An analysis of all types of plans existing in this country is being made by a Committee of the Council on Medical Service. There are not too many, but each one contributes something worthwhile. We hope this will help in fitting a plan to your local needs, as well as stimulating interest in the problem in general.

Chronic illness and care of the aged, ever increasing problems, dip deeply into the rural areas. All of these are receiving special study and attention. We must not overlook the necessity of fitting them into our overall plans for looking after rural groups.

It is possible only to touch lightly upon the many aspects of rural medical needs, but we must not forget such diseases common to animals and man, as brucellosis, which annually causes so much loss to the farmer and results in chronic illness and economic loss to the population as a whole. Doctors, farmers, veterinarians and the government must work together towards a solution of such problems. Why not attack brucellosis with the same vigor as that used in eradicating bovine tuberculosis as a menace?

The Woman's Auxiliary can contact the farm women, and even become members of their organizations. In this way they may help educate these people about medical care and help them solve the worst of the medical problems in their rural communities.

"Therapeutic" bile

In biliary tract disorders bile itself can be "therapeutic" – when the bile flow evoked is abundant and fluid, serving to flush the biliary tre of mucus, pus, particulate matter and thickened bi

Bile of this "therapeutic" character – copious in volume and low in viscosity – is produced by the specific hydrocholeretic action of *Decholin* a *Decholin Sodium*. These agents are especially valuable in nonsurgical drainage therapy of chronic cholecystitis, noncalculous cholangitis a biliary dyskinesia, and before and after surgery of the tract.

Adequate dosage of *Decholin* for most patients requires one or two tablets three times daily fo 4 to 6 weeks. Prescription of 100 tablets is recommended for maximum efficiency and economy. More prompt and intensive hydrocholeresis may be achieved by initiating therapy with *Decholin Sodium* 5 cc. to 10 cc., intravenously, once daily.

Decholin and Decholin Sodium

Decholin (brand of dehydrocholic acid)
Tablets of 3¾ gr. in bottles of 100, 500, 1000 and 5000

Decholin Sodium (brand of sodium dehydrocholate)
20% aqueous solution, ampuls of 3 cc., 5 cc., and 10 cc in boxes of 3, 20 and 100.

Decholin and *Decholin Sodium*, trademarks reg.

AMES

AMES COMPANY, INC · ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

ORIGINAL ARTICLES

Management of Retroversions and Retroflexions of the Uterus in General Practice

Retrodisplacements of the uterus cause symptoms referable to the back and abdomen.

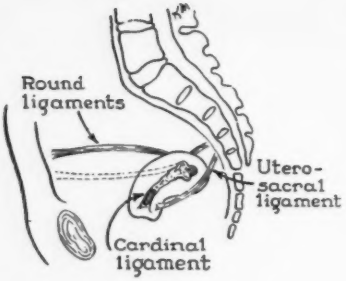
JOHN R. McCAIN, M.D., *Department of Obstetrics and Gynecology, Emory University School of Medicine and Grady Memorial Hospital, Atlanta, Georgia*

The surgical correction of retrodisplacements of the uterus continues to be one of the most widely abused procedures in gynecologic practice.[1] Many patients are advised to have a suspension operation performed as soon as a retrodisplaced uterus is found. The reasons most frequently given for immediate operation are (1) that suspension of the retrodisplaced uterus will relieve any gynecologic complaints the patient may have, or (2) that "Your womb is out of place and you will never be able to become pregnant unless it is corrected." Advice of this type does not recognize the limited usefulness of operations to correct the position of the uterus.

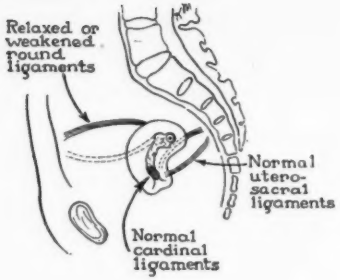
Retrodisplacements of the uterus are found at pelvic examination in about 20 per cent of women in the child-bearing years.[2,3] The high incidence of this condition and the frequency with which its operative correction is abused make it desirable for the general practitioner to determine those cases in which treatment is not required, those in which treatment may consist of local measures, and those in which surgical procedures should be carried out.

1 Baldy, J.: *S. G. & O.* 20:614, 1915.

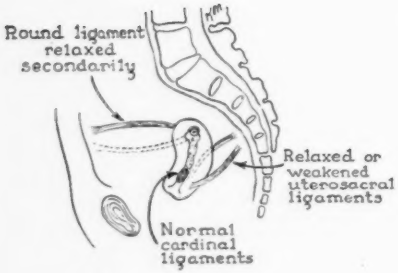
2. Stacy, Leda J.: *J. A. M. A.* 79:793, 1922.
3. Danforth, W. C., and Galloway, C. E.: *J. A. M. A.* 87:826, 1926.



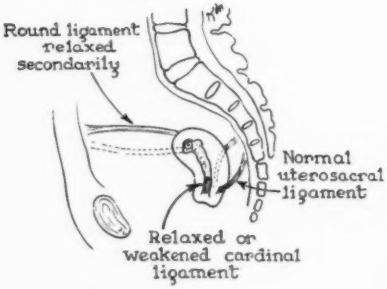
"Simple" Retrodisplacement



Retroflexion of the Uterus



Retroversion of the Uterus



Retrocession of the Uterus

The purpose of this paper is to review the subject of retrodisplacements of the uterus so that unnecessary operations can be avoided and so that patients will not be disappointed in the amount of relief obtained after the position of the uterus has been corrected.

ETIOLOGY

Retrodisplacement of the uterus results from a congenital or acquired relaxation and weakening of the pelvic ligaments which normally maintain the uterus in its correct position. Changes in intra-abdominal pressure and in distention of the bladder and rectum serve to modify the position of the uterus, but the major support of the uterus is given by its ligaments. "Retrodisplacements of the uterus" include the retroflexion, retroversion and retrocession.

The uterus is *retroflexed* if the body of the uterus is flexed posteriorly while the cervix is in its normal position. Retroflexion is permitted if the round ligaments become relaxed.

In *retroversion,* the uterus rotates

upon an axis in the transverse plane of the pelvis at about the junction of the cervix with the body of the uterus. The axis for the rotation consists of the cardinal (Mackenrodt's) ligaments. The body of the uterus is displaced toward the cul-de-sac and the cervix rotates forward. Retroversion occurs if the uterosacral ligaments become relaxed and no longer hold the cerivx toward the sacrum.

Retrocession is present if the uterus lies farther toward the sacrum than normal and occurs if the cardinal ligaments are relaxed. The uterus may have normal anteflexion and anteversion, or it may have retroflexion or retroversion combined with the retrocession.

Prolapse, or *descensus,* of the uterus occurs if the relaxed ligaments permit the uterus to lie nearer the vaginal introitus. It is often associated with the retrodisplacements of the uterus.

If relaxation involving one pair of pelvic ligaments occurs, the other ligaments usually are affected. Therefore, in actual experience the type of retrodisplacement most frequently encountered consists of retroversion of the uterus with associated retroflexion and retrocession. A descensus of the uterus is also present in many of these cases.

"Simple," or uncomplicated, retrodisplacement of the uterus is produced by the absence or relaxation of the supporting ligaments and is not associated with other pathologic conditions in the pelvis. Simple retrodisplacements may be either congenital or acquired. In the congenital type, the ligaments supporting the uterus were never able to maintain it in an anterior position. In the acquired type, the ligaments may become so relaxed or weakened during the woman's life (especially by such events as childbirth) that they permit the uterus to become retrodisplaced. Accordingly, the uterus with an uncomplicated type of retrodisplacement is usually movable. It is ordinarily possible to move the uterus into, or at least toward, an anterior position during pelvic examination.

"Complicated" retrodisplacements of the uterus are ones associated with, and often caused by, other pelvic pathology. The abnormalities most frequently found with retrodisplacements of this type include endometriosis; pelvic inflammatory disease; other pathologic conditions of the tubes and ovaries; fibromyomas of the uterus; and postpartum relaxations such as cystocele, rectocele, and descensus of the uterus. These complications may develop in cases in which simple retroversion is present and may further the displacement of the uterus or may be the cause of the retrodisplacement. The uterus with a complicated retrodisplacement is frequently fixed in position. Attempts during a pelvic examination to replace the uterus anteriorly are often unsuccessful.

SYMPTOMS

Many symptoms have been attributed to retrodisplacement of the uterus. However, simple retrodisplacements are rarely symptomatic, and the symptoms of patients with complicated retrodisplacements are much more likely to be caused by the other pelvic pathology than by the abnormal position of the uterus itself. It should be remembered that that the presence of a retrodisplaced uterus in a patient with pelvic complaints does not necessarily prove that these complaints are the result of the retrodisplacement. The symptoms often attributed to abnor-

mal positions of the uterus are discussed in the following paragraphs.

Lumbosacral backache and *lower abdominal pressure symptoms* can be caused by retrodisplacements of the uterus. The backache and pressure symptoms from an abnormal position of the uterus should be aggravated by exercise or by the erect position and should tend to be relieved by rest and by the recumbent position. If symptoms are produced at all by the retrodisplacement itself, they are most frequently of this type.

Dysmenorrhea and dyspareunia can be produced by retrodisplacement but are caused much oftener by other conditions.

Abortion is rarely caused by retrodisplacement. Early abortion should not be attributed to the position of the uterus. Retrodisplacement of the uterus may sometimes be responsible for abortions occurring in the third or fourth month of gestation. It is at this stage in pregnancy that the position of the retrodisplaced uterus must change if it is to rise out of the pelvis and not become incarcerated. However, other causes for abortion should be eliminated before surgical correction of the uterine position is attempted to prevent this complication.

Sterility is practically never produced by the retrodisplacement of the uterus. If postcoital examination of the cervical secretion reveals the presence of active spermatozoa, the sterility should not be ascribed to the position of the uterus.

The only menstrual disturbance which can be attributed to a retrodisplaced uterus is an excessive amount of bleeding. Retrodisplacement may interfere with the normal vascularity of the uterus and produce some engorgement of the endometrium. At menstruation, the vascular congestion may permit excessive bleeding.

Leukorrhea is not attributable to variations in the position of the uterus.

TREATMENT

Potential dangers from retrodisplacement—It has been claimed that retrodisplacement of the uterus may eventually cause complications such as endometriosis, sterility, habitual abortion, or ovarian dysfunction. The impression that complications of this type may occur in the future has caused some physicians to advocate surgical correction without delay for even asymptomatic retrodisplacements. However, no proof has ever been given that these pathologic conditions have been caused or aggravated by a delay in correcting an asymptomatic retrodisplaced uterus. The surgical correction of asymptomatic retrodisplacements should never be advised in the hope that the change in the position of the uterus will prevent future pelvic pathology.

Even if the patient is now symptomatic it should be remembered that the necessity for treatment is not urgent. The symptoms from a simple retrodisplacement are not likely to become more severe because of a delay in treatment. The possibility that the symptoms and dangers of a patient with a complicated retrodisplacement might increase in the future depends entirely upon the nature of the additional pelvic pathology. A retrodisplacement of the uterus, either symptomatic or asymptomatic, is never an indication for an emergency surgical operation.

Selection of patients for operation—The success of a suspension operation in relieving a patient's symptoms has definite limitations. Most

symptomatic retrodisplacements also have additional pelvic pathology and these complications should determine the necessity for operation. The uterus may be suspended as a part of the operative procedure, but relief cannot be expected unless the additional abnormalities are also corrected.

The possibility of success from the surgical correction of a simple retrodisplacement of the uterus can be determined rather accurately preoperatively. The success will correspond to the amount of relief obtained from the use of a vaginal pessary to elevate the uterus toward its normal position. A Smith-Hodge or similar type of vaginal pessary is inserted to hold the uterus out of its retrodisplaced position. It is not necessary that the position be completely corrected. If relief is obtained, the pessary should be left in place through two menstrual periods. The pessary is then removed for one month, and often the patient's symptoms do not recur and further treatment is not necessary. If the symptoms return, the pessary is reinserted for another month. If relief is obtained again, the patient can be assured that a surgical suspension will be of real value to her. Unless the symptoms are decreased by the pessary a surgical suspension of the uterus cannot be expected to give relief. Proper surgical judgment cannot be exercised if a uterine suspension is undertaken for a simple retrodisplacement before this therapeutic test has been employed. Even in patients with complicated retrodisplacements the pessary test is often useful in the evaluation of the patient before operatiion.

In the months after childbirth, lumbosacral backaches and lower abdominal discomforts are frequent. If these women have a pelvic examination, approximately one-third of them will be found to have a retrodisplaced uterus.[4] However, most of the complaints of these patients are due to the strenuous demands of their infants and are not at all related to the position of the uterus. Therefore, the surgical correction of a retrodisplacement of the uterus should rarely be undertaken during the first year after a delivery.

The age of the patient also modifies the type of treatment. A suspension of the uterus is almost never indicated for a patient over forty years of age. If a laparotomy is indicated for retrodisplacements of the uterus (or, for almost any abnormality of the uterus) in women at this age, the uterus itself should usually be removed.

TYPES OF OPERATION

Many surgical technics are available for the suspension of the uterus.[5] If the operation is to be successful in relieving the patient's complaints, the careful selection of the patient for surgery is far more important than the type of the operative procedure. Most of the operations involve a shortening of the round ligaments. Even more important is the plication of the uterosacral ligaments for the purpose of shortening them. The shortened uterosacral ligaments cause the cervix to rotate toward the sacrum on the axis of the cardinal ligaments, and the fundus is brought forward by this change.

SUMMARY

Lumbosacral backache and/or low abdominal pressure symptoms, relieved by rest, are the only complaints caused with any frequency by retrodisplacements of the uterus. Simple retrodisplacements of the uterus are rarely symptomatic and

4. Moses, S. H.: *Am. J. Obst. and Gynec.* 37: 447, 1939.
5. TeLinde, R. W.: *Operative Gynecology*, J. B. Lippincott Co., Philadelphia, 1946, p. 96.

operative treatment is rarely indicated.

Before advising a surgical suspension for a simple retrodisplacement of the uterus, a therapeutic test should be employed to determine the amount of relief which can be obtained by the change in the position of the uterus. This test involves the use of a vaginal pessary for four months. The symptoms of patients with complicated retrodisplacements are rarely caused by the altered position of the uterus. The indications for surgical intervention should be determined by the additional pathology which is producing the symptoms.

The suspension of the uterus alone will not relieve a patient's symptoms if additional complications are present, such as primary dysmenorrhea, endometriosis, pelvic inflammatory disease, or vaginal relaxations. A retrodisplacement of the uterus is never an indication for urgent surgical treatment. Suspensions of the uterus are almost never indicated during the first year after childbirth or in patients over 40 years of age. Satisfactory results from surgical suspensions of the uterus can best be obtained by the careful selection of the patients for the operation. The exact operative technic is relatively unimportant.

POLIOMYELITIS

Prior to 1880, many physicians regarded poliomyelitis as a type of club foot or as a result of reflex paralysis from teething. Evidence exists that true epidemics of poliomyelitis appeared in several forms, the following, which appeared in the *American Journal of Medical Science* in 1843, being most frequently cited:

"Medical Notes. By George Colmer. — Paralysis in Teething Children. Whilst on a visit to the parish of West Feliciana, La., in the fall of 1841, my attention was called to a child about a year old, then slowly recovering from an attack of Hemiplegia. The parents (who were people of intelligence and unquestionable veracity), told me that eight or ten other cases of either hemiplegia or paraplegia, had occurred during the preceding three or four months within a few miles of their residence, all of which had either completely recovered, or were decidedly improving. The little sufferers were invariably under two years of age, and the cause seemed to be the same in all — namely, teething."

Culdoscopy

Technic in use of this valuable diagnostic instrument in gynecologic practice.

DONALD C. SCHWEIZER, M.D., *Greensboro, North Carolina*

Culdoscopy is an endoscopic procedure whereby the internal female pelvis is viewed directly by a light and lens system through the posterior cul-de-sac of the pelvis. The purpose of this paper is to summarize the essential facts of the procedure and evaluate it from a practical point of view.

Since the peritoneoscope was introduced in 1902, there has been much dissatisfaction with its use for visualization of the pelvic viscera, both because of the poor view and the hazard of peritoneoscopy itself. About ten years ago Decker developed the instrument called the "culdoscope," which now has become an accepted diagnostic aid. The instrument itself is similar to an ordinary cystoscope, using a lens system with a terminal light. It is introduced into the pelvis through the posterior vaginal vault or cul-de-sac. The essential feature of the procedure as developed by Decker is the use of the knee-chest position. This position takes advantage of reduced intra-abdominal pressure so that when puncture is made, the abdominal viscera fall out of the way and makes visualization of the pelvis relatively easy.

The culdoscope is primarily a diagnostic instrument, although recent papers have described its use therapeutically for tubal occlusion. Since this paper is written from a personal viewpoint, discussion will be confined to diagnosis. Therapeutic use of this device is still in the stage of development and in the writer's opinion, quite limited.

DIAGNOSTIC USE

There is a natural tendency for authors on this subject to extend their use of this valuable instrument as far as possible, but for all practical purposes, three broad diagnostic indications can be laid down.

Pelvic pain of undetermined origin—This would mean that pelvic ex-

amination would necessarily prove unsatisfactory and the pain of sufficient intensity to demand further investigation short of laparotomy. Specific cases in this group might include ectopic pregnancy, ruptured or twisted cysts, endometriosis and inflammatory states. Endometriosis is probably one of the commonest indications for the use of the culdoscope as diagnosis is notoriously difficult and physical findings may be minimal. Along the same line, a negative culdoscopic examination may be exceedingly valuable in ruling out pelvic pathologic processes to help establish a suspected diagnosis of the all too common psychosomatic type of pain.

Pelvic masses of undetermined type—Here again, this would mean masses that could not be classified by pelvic examination, with or without anesthesia, and yet not of sufficient size or symptoms to demand laparotomy. This group might include such conditions as unruptured ectopic pregnancy, ovarian cysts, adhesions or inflammatory states.

Infertility studies—Most of the recent papers on culdoscopy stress use of the instrument in infertility studies, especially in localizing tubal occlusion by means of dye injected into the Fallopian tubes. They further point out the possibility of their correction by this knowledge and even using high insufflation pressures under direct vision. Personal experience confirms the fact that tubal occlusion can be diagnosed but seems to offer little or no advantage over ordinary methods of tubal insufflation or roentgenograms using radiopaque media. An exceptional case could conceivably be found where culdoscopy would reveal a correctible condition causing tubal blockage.

To reiterate, experience has shown this instrument to be of its greatest value in diagnosis where pelvic pain is the primary complaint and, to a less degree, in the case of a pelvic mass. Its further use in sterility studies undoubtedly will be broadened by other workers. The culdoscope will probably be used relatively infrequently by any one individual, but it is an instrument of great value when needed and should be available to every gynecologist.

TECHNIC

The technic of the use of the culdoscope is relatively simple. The patient is prepared by shaving the vulva, giving of an enema and preoperative sedation, as for most vaginal procedures. Many workers advocate the use of local anesthesia but the patient often complains of being in the knee-chest position for any length of time. The following routine has been found ordinarily satisfactory:

The patient is placed in the knee-chest position while awake because a balance point can be obtained with the patient's cooperation. A pillow is placed under the chest and head to facilitate breathing. The balanced thighs are then taped to stirrup uprights and the patient anesthetized with sodium pentothal. The perineum and vagina are prepared with an antiseptic and draped with sterile towels and sheets.

A Sims speculum is introduced into the vagina and upward traction made by an assistant so that the posterior vaginal vault is tensed. A tenaculum placed on the cervix is pulled downward at the same time. The sharp trocar of the culdoscope is then inserted through the center point of the cul-de-sac and the stylet withdrawn. If entry has been correct, air will rush in audibly.

The telescope is introduced through the sheath and inspection can be made. The telescope may be

moved in any direction. Traction on the cervix will aid in the movement. Vision is remarkably clear and the size of the object viewed is either the same, enlarged or smaller than actual, depending upon how close the lens is to it. Practice soon enables the operator to judge this. Ordinarily the posterior surface of the uterus, both ovaries and tubes, the pelvic walls and some loops of intestine can be seen clearly. Rarely the appendix is in view.

The most common error in technic is to try to stay too close to the cervix when inserting the trocar, so as to avoid the rectum. This often results in a peeling up of the visceral peritoneum without perforation and usually cannot be remedied by continued manipulation. Often the lens will fog until it warms in the body, so hot water beforehand prevents this. The telescope can be withdrawn and wiped off at any time since the cannula remains stationary.

Removal of the instrument is almost as important as its insertion. The tenaculum, speculum and telescope are removed and the cannula left in place. The patient's legs are freed and she is slid forward with pressure under the abdomen to expell as much air as possible, then the cannula is withdrawn. The cul-de-sac puncture requires no after care. If care is not taken with expression of air, considerable pain of the shoulders results for two or three days.

The entire procedure is safe, no serious complications having occurred. Puncture of the rectum was accomplished once with actual visualization of feces. The instrument was withdrawn and no complications developed. This has been reported several times, all without harm. The only contraindications are occlusion of the cul-de-sac and inability of the patient to assume the knee-chest position for any reason.

SUMMARY

Culdoscopy is a simple, safe procedure for visualization of the pelvic viscera. Its technic is easily mastered and visual clarity is of such a degree as to make diagnosis relatively easy. Its greatest value probably lies in cases of undertermined pelvic pain or masses. Its individual need is limited but when needed is exceedingly valuable and should be available and within the scope of every gynecologist.

The drawbacks to the device are several: Occasionally a technical failure will result but these become less and less frequent with practice. Secondly, hospitalization and usually general anesthesia is required and lastly, but rarely, it is not possible to identify what is seen through the culdoscope. All in all, however, the culdoscope should be considered a valuable addition to our diagnostic armamentarium.

HIPPOCRATES ON DIET

"Growing bodies have the most innate heat; they therefore require the most food, for otherwise their bodies are wasted. In old persons the heat is feeble, and therefore they require little fuel, as it were, to the flame, for it would be extinguished by much. On this account, also, fevers in old persons are not equally acute, because their bodies are old."

RECOMMENDED READING ON

BUTAZOLIDIN

(brand of phenylbutazone)

for

ARTHRITIS

and allied disorders

new... synthetic...

non-hormonal...

orally effective

The remarkable clinical effectiveness of BUTAZOLIDIN in producing striking relief of pain, coupled with functional improvement, is the subject of recent authoritative reports.

Journal of the American Medical Association* 149:*729 (June 21) 1952.

Kuzell, W. C., and others: Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis and Gout.

Gout: "... 25 of the 48 gouty patients experienced a complete remission in 48 hours or less."

Journal of the American Medical Association* 150:*1087 (Nov. 15) 1952.

Steinbrocker, O., and others: Phenylbutazone Therapy of Arthritis and Other Painful Musculoskeletal Disorders.

Osteoarthritis: In 63 per cent "... there was improvement of functional capacity ranging from slight to complete, with striking enhancement of coordinated movements...."

Journal of the American Medical Association* 150:*1084 (Nov. 15) 1952.

Stephens, C. A. L., Jr., and others: Benefits and Toxicity of Phenylbutazone (Butazolidin®) in Rheumatoid Arthritis.

Spondylitis: "Of the 32 patients ... 25 patients (80%) showed 3 to 4 plus subjective improvement."

Bulletin on Rheumatic Diseases* 3:*23, 1952.

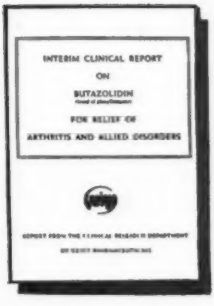
Kuzell, W. C.: Phenylbutazone (Butazolidin®).

Rheumatoid arthritis: "Its use is followed by substantial relief of symptoms in about 80 per cent of patients with rheumatoid arthritis."

from the clinical research
department of Geigy Pharmaceuticals

AN INTERIM REPORT on

BUTAZOLIDIN



First of a series, the Interim Clinical Report on BUTAZOLIDIN summarizes and analyzes the literature on this important new agent. Mailed recently to the medical profession, additional copies are available on request.

BUTAZOLIDIN is a totally new and outstandingly effective agent in the therapy of virtually all forms of arthritis. In most indications it produces relief of pain in approximately 75 per cent of cases and measurable functional improvement in 50 per cent.

In relation to its high degree of effectiveness BUTAZOLIDIN is of relatively low toxicity. However, to obtain optimal results with minimal risk of side reactions physicians are urged to read the mentioned reports in their entirety.

Physicians are also invited to write our Medical Department for the brochure, "Essential Clinical Data on BUTAZOLIDIN," *and other informative literature.*

BUTAZOLIDIN® (brand of phenylbutazone) is available as coated tablets of 100 mg. and 200 mg.

GEIGY PHARMACEUTICALS
Division of Geigy Company, Inc.
220 Church Street, New York 13, N.Y.

CLINICAL REFRESHER

Postcholecystectomy Syndrome

G. B. HODGE, M.D., *Spartanburg, South Carolina*

The persistance of biliary symptoms following operation on the gall bladder is common, as approximately 10 per cent of patients undergoing biliary operations will continue to have ensuing symptoms in varying degrees.

Fortunately, in most of these cases symptoms referable to the biliary tract are transitory and are usually characterized by gaseous distention, eructation, and epigastric discomfort and dyspepsia. In a relatively few, the symptoms may be identical or more severe than previous to operation.

The common causes for the postcholecystectomy syndrome are cholangitis or hepatitis, common duct calculi or common duct stenosis, spasm of the sphincter of Oddi, pancreatitis, persistent long cystic duct, anomalies of the common and pancreatic ducts, pericholedochal postoperative neuromas, adhesions, and neoplasm.

Secondary operations are indicated in most of the aforementioned causes except in cases of hepatitis and cholangitis which respond to antibiotic therapy and duodenal suction drainage. Choledochotomy with common duct exploration for stricture, stones, anomalies, and sphincter of Oddi spasm or stenosis or neoplasm is carried out. T-tube drainage of the common bile duct for a protracted time usually gives relief. Before the T-tubes are removed, a contrast cholangiogram should be made. Many of these cases may be spared this undesirable postcholecystectomy syndrome by thorough preoperative clinical evaluation and correct diagnosis. Biliary operation is major in character and should not be attempted by anyone not experienced in the many varieties of the pathologic processes and complications that are attendant in biliary diseases.

By such an approach to the problem, the incidence of undesirable postoperative symptoms and findings should be reduced substantially.

Vitamin E in the Treatment of Diseases of the Skin

The aqueous solution of this vitamin shows promising results in treatment of many types of skin lesions.

MARCUS T. BLOCK, M.D., *Newark, New Jersey*

In the modern treatment of diseases of the skin, it has become necessary, in addition to local applications, to treat or modify tissues beneath the skin in order to accomplish the objective appearance of a clear integument. This can be accomplished by employment of the newer therapeutic agents, such as vitamins, hormones and antibiotics, in addition to the older drugs.

The purpose of this paper is to discuss the results which vitamin therapy, particularly vitamin E, has produced in diseases of the skin. It is increasingly apparent that vitamin E can relieve a variety of conditions hitherto considered unable to be handled in a satisfactory manner. In short, we have an agent at this time that can relieve and also cure many diseases which formerly caused physicians to tell their patients that "They must learn to live with their disease."

TYPES OF DISORDERS

The best results in my experience have been obtained in those morbid processes in which the vascular and collagenous systems are disturbed. These would include the following dermatologic disorders:

1. Ulcerations anywhere on the body, regardless of etiology.
2. Varicose eczema and stasis dermatitis.
3. Collagenous disorders, particularly lupus erythematosus of the chronic discoid type.
4. Malignant disorders, particularly the superficial types such as basal cell epithelioma, small, fairly well differentiated squamous cell epithelioma, and premalignant senile keratosis.
5. The appearance of evidence of diabetes on the skin, such as necrobiosis lipoidica diabeticorum, for which vitamin E

is specific, and other xanthomatous conditions.

6. Menopausal pruritus.
7. Unhealed surgical wounds and wound infections.
8. Roentgen ray burns.
9. Granulomatous tissue.
10. The variety of conditions producing dry scaly skin, such as ichthyosis, seborrhea sicca (dry dandruff), dry eczema, hitherto referred only as far as vitamins are concerned as due to vitamin A or B Complex (riboflavin factor) deficiencies.
11. Diabetic gangrene. It is almost axiomatic to use vitamin E in conjunction with antibiotics, as soon as possible. Even late doses prevent amputation and debridement.
12. Leukoplakia.

DOSAGE

In the treatment of these diseases and others requiring vitamin E, large doses are necessary. Small doses, even if given often, are valueless and will only cause disappointment as far as therapeutic results are concerned. The dosage to be given varies according to the severity of the case.

Usually, 100 mg. of vitamin E given orally three times a day after meals, plus intramuscular administration of 150 mg. of vitamin E in an aqueous solution* twice weekly, give satisfactory results. In cases in which the condition is severe, the oral dosage should be increased to 200 mg. per dose, plus 150 mg. given parenterally three times a week.

SIDE EFFECTS

Side effects sometimes appear after administration of vitamin E, such as oiliness of the scalp and face with acneform eruptions, including comedones. The reaction is reversible and disappears on cessation of administration. Other side effects are nausea and abdominal discomfort on oral administration. The intramuscular injection in some cases produce a localized swelling and some pain. The solution in oil may give rise to an occasional oil granuloma. Abdominal discomfort should indicate that oral administration be discontinued. The large majority of reactions following parenteral administration can be eliminated by vigorous massage immediately following injection plus hyaluronidase given subcutaneously in the same area immediately before vitamin E is injected. If oral administration is not feasible, parenteral administration of the aqueous suspension in doses of 75 mg. daily should be used plus hyaluronidase (100 turbidity units) in the same site before injection.

Rarely, swelling of the breasts, increased libido, and hypertrophy of the labia occur.

RESULTS

A summary of the results obtained by administration of vitamin E may be seen in Table 1. In condition 1, some of these patients were charity cases and were not nourished properly nor was proper hygiene practiced as a habit. Too, these patients did not keep appointments regularly, hence I feel that the results would have been better among more cooperative patients or among those whose daily mode of living was more conducive to health.

In the three poor results obtained in condition 2, administration of 1000 mcg. of Vitamin B_{12} intramuscularly twice weekly for twelve doses brought about complete clearing of the lesions.

*The aqueous solution used in this study was Hydrotocopherol, Farnsworth Laboratories, Chicago, Illinois.

TABLE 1

Summary of Results Obtained with Vitamin E

Disease	No. of patients	Results		
		Excellent	Good	Poor
1. Varicose Ulcer and Varicose Eczema	25	18	4	3
2. Lupus Erythematosus	12	8	1	3
3. Basal Cell Epitheliomas	20 (5 yr. cure)	15	3	2
4. Squamous Cell Epitheliomas	5 (5 yr. cure)	3		2
5. Necrobiosis Lipoidica Diabeticorum	2	2		
6. Menopausal Pruritis in the female	10	8	2	
7. Unhealed Surgical Wounds	4	4		
8. Roentgen Burns	2	2		
9. Diabetic Gangrene of the Toes	3	3		
10. Dry Scaly Skin-Ichthyosis: Seborrhea Sicca — Dry Dandruff	8	5	3	
11. Leukoplakia	4		2	2

In the two cases of failure in condition 3, the lesions were too large and deep for thorough curettage. Roentgen therapy was used successfully in these cases. In my opinion, all basal cell epitheliomas up to the size of a penny (¾ inches in diameter) should clear if thorough curettage is first carried out, followed by large doses of vitamin E. Larger and deeper lesions may need roentgen therapy or operation.

In condition 4, one patient with squamous cell carcinoma and one with recurrent nodules following hysterectomy and then treated with vitamin E are still living. In the other two cases, recurrence and death occurred.

In condition 5, in one severe case of necrobiosis lipoidica diabeticorum of twenty years duration, all ulceration healed within two weeks after treatment was instituted.

Conditions 6, 7, 8 and 9 need no explanation.

In condition 10, the action is probably due to the side reaction of oiliness produced by vitamin E.

Of the four patients in condition 11, consisting of three cases of lesions on the lips and mouth and one on the vagina, death occurred in two from rapidly growing squamous cell carcinoma. In the other two cases, 1000 mcg. of vitamin B_{12} was given intramuscularly, with arrest of the disease process.

REPORTS OF CASES

Case 1—A woman had a large, yellow ulcerating lesion on the right leg, diagnosed at biopsy as necrobiosis lipoidica diabeticorum. Parenteral administration of 150 mg. of vitamin E twice weekly, plus oral administration of 100 mg. of vitamin E three times a day after meals, produced closing of the ulcers in two weeks and the beginning of normal skin formation.

Case 2—A woman had three lesions diagnosed as necrobiosis lipoidica

diabeticorum, which had been present for one year. Administration of vitamin E as employed in Case 1 brought about clearing of the lesions in three weeks.

Case 3—A woman who had a basal cell epithelioma on the side of the face had been inadequately treated with roentgen rays, which had made the lesion radio-resistant to full healing. Parenteral administration of 150 mg. of vitamin E three times a week, plus oral administration of 100 mg. of vitamin E three times a day after meals brought about healing.

Case 4—A woman had undergone mastectomy for squamous cell carcinoma, with recurrence of nodules. Injection of 150 mg. of vitamin E three times a week, plus oral administration of 100 mg. of vitamin E three times a day after meals, brought about clearing of nodules for two years.

SUMMARY

Vitamin E is an excellent contribution to the therapeutic armamentarium of a large number of skin diseases and will earn the patients' eternal gratitude for the proper appearance of the skin. I must again emphasize that this medication cannot be expected to give results if used in homeopathic doses.

ARTHRITIS AND RHEUMATISM

The author presents a survey of arthritis and rheumatism as performed in September, 1951, in the United States. According to this survey, the estimate is that there are approximately 10,104,000 persons, 14 years and over, in the United States who believe that they have arthritis or rheumatism. About 75% of these persons have consulted a physician because of their condition. An estimated total of 6,414,000 have been told by a doctor that their condition was arthritis, rheumatism, gout, lumbago, myositis, or fibrositis. About 5% of the 10,000,000 persons who believe that they have one of these impairments apparently do not; others must also be considered doubtful cases. However, about one-fourth of the 10,000,000 cases had made some significant change in the amount or type of work they performed or in their usual activities. (Woolsey, Ph.D., *Public Health Reports*, 6:505, 1952.)

Skin Grafting as an Office Procedure

Small ulcers and skin defects may be amenable to skin grafting if they cannot be closed by approximation.

WILSON A. SWANKER, M.D., *New York, New York*

The continuity of the cutaneous covering of the body is most important to the well being of the individual. The use of the skin graft to cover large denuded areas, such as burns, or the specific small areas, such as avulsed finger tips, is a well accepted procedure. If this is true, why is not skin grafting performed in the case of the lesser denudations?

INTENT OF TREATMENT

The major features of the treatment of a traumatized area are aversion of infection and rapid healing with minimal scarring. The advent of infection is reduced by thorough initial cleansing of the wound. Gross contaminants, such as dirt and foreign bodies, are removed. The area is cleansed with soap and water and an antiseptic solution. If the edges of the wound can be approximated, rapid healing will undoubtedly occur. If the edges cannot be approximated, the use of a skin graft should be considered after the wound has been made as shallow as possible by subcutaneous suturing to approximate the deeper tissues.

The matter of minimal scarring requires further consideration. Healing by primary intention will create the least scar. However, such scarring can be decreased by careful approximation of the skin edges in slight elevation. There should be little or no strain on the skin itself. Any tension can be taken up by subcutaneous suturing or by supportive dressings. When the use of a skin graft is found to be necessary, its early application will minimize the amount of scar. In most injuries, the surgical cleansing of the wound would well prepare it for a graft if it is of the type in which the edges cannot be approximated. If injection has occured, early control by wet soaks and systemic use of antibi-

otics will tend to control it, but valuable time will be lost and further scarring will occur. A belief that a wound should be permitted to "granulate in" before grafting has been discarded as obsolete. Granulation tissue is a precursor of scar tissue. It will eventually give a graft overlying it a thickened, roughened appearance. A split skin graft will take very well on the subcutaneous fat. In fact, it will take on muscle, fascia or bone, but a soft moveable base is preferred.

OFFICE EQUIPMENT

It is natural to feel that large areas of denudation should be grafted with a single piece of skin if it is possible. This suggests the need for a dermatome and hospitalization of the patient. Even a dermatome graft (4x8 inches) could be performed as an office procedure, but it is not usual as most physicians do not have the equipment available. However, this type of graft is not designated as an office procedure.

The small areas of skin loss, from the smallest ulcer to an area of 3 or 4 square inches, can be clothed with split skin with simple instruments that are available in most medical offices.

The equipment needed is several double-edged safety razor blades, a Kelly hemostat, a small thumb forceps, a 5 or 10cc. syringe, sterile petroleum jelly, and an anesthetic solution. In the office I prefer to use Monocaine Solution 1 per cent with 1:100,000 epinephrine (Novocal Chem. Co.) because it is prepared in 5 cc. cartridges to fit a syringe furnished by the company, which greatly facilitates the sterilization problem. The razor blade is grasped in the Kelly hemostat just to one side and somewhat parallel to the center slot. This leaves about two-thirds of the razor blade extending from one side of the hemostat. If a curved Kelly hemostat is used, the same amount of blade should extend from the convex side of the curve.

TECHNIC

A donor site is selected which is near the recipient area so that the grafted skin will have the same skin tone and texture. It is always wise to select as hairless an area as possible to avoid the transfer of hair-bearing skin and to facilitate cutting of the graft. If a hair-bearing area must be used, the graft should be cut *against* the hair.

The technic itself is a simple one. The surgically clean donor site is lightly smeared with petroleum jelly. The razor blade held in the Kelly hemostat is also anointed with a thin film. With the skin drawn taut by the left hand, the razor blade is placed flat against the skin at a predetermined point. With the arm fixed at the wrist and elbow so that a short forward and backward motion is initiated in the shoulder and a slight pressure made on the cutting edge of the blade, the skin graft is cut. This coordinate motion should be slow and rhythmic and, if the position is not awkward, it should be tireless.

The depth of the cut is controlled by watching the translucency of the skin. If the razor blade can be seen, the thickness of skin will be from 5/1000 to 7/1000 of an inch. If the translucence is such that only a blue-gray color is distinguishable, the thickness of skin is from 10 to 12/1000 of an inch, which is the preferred depth. Thicker grafts appear yellowish-white in color and their thickness is difficult to control by vision.

There is no limit to the length of the strip of skin that can be raised

by this method except the size of the donor area. The first grafts raised will be short until mastery of the technic has been accomplished. This is of little importance, as every piece of skin has utility. During the cutting, the skin piles up on the razor blade and it should be transported from the donor site to the recipient area on the razor blade. The cutting edge of the razor blade is brought in contact with the far edge of the recipient area and the edge of the skin graft is teased off the blade and on to the site with the small thumb forceps. This skin is held in place with the forceps while the razor blade is swung over the site, depositing the skin graft on to the recipient almost in the desired position. A very little "teasing out" of this skin will find it smoothly in place. It will be noticed that there has been as little manipulation of the skin graft as possible and all the fibrogenic elements are maintained. These elements will quickly form the fibrin which will cement the graft in place. In fact, this adhesion can be demonstrated in a few minutes.

If the area is broader than the width of one strip, other strips may be placed beside the first until the defect is covered. This covering should overlay the edges slightly.

The area is dressed with a fluffed gauze pressure dressing bandaged in place. The graft may or may not be initially covered with a single thickness of petroleum gauze, but its use makes redressing easier. Either gauze bandage or elastic bandage may be used but in either case the pressure created should not be greater than 30 mm. of mercury. (This is true of all bandaging and one can learn the force to apply by bandaging a blood pressure cuff inflated to 30 mm. without increasing the pressure). The bandage should remain undisturbed for ten days unless complication is indicated by drainage or odor. If such complication does occur, inspection should be immediate. However, the dressing should be removed down to the last layer only, through which the area can be observed without disturbing the graft. With or without complication, it is best to allow this layer of gauze to free itself. The donor site is treated in the same way.

SUMMARY

One can readily see the many opportunities to employ this simple procedure. Rather than the long weeks required to heal areas slowly by ingrowth of the surrounding epithelium with the resulting scar, the skin graft can rehabilitate the patient in two to three weeks with much less scar formation. This technic can be used on small third degree burns, avulsions, small ulcers, and any clean skin defect that cannot be closed by approximation.

PLASTIC DRESSING

The Air Force has announced development of a "spray-on" plastic surgical dressing, equally applicable for possible emergency use or as a substitute for gauze dressings. The "aeroplast" is applied by spraying over the traumatized area. A film approximately 5/1000 of an inch thick is formed, which is impermeable to bacteria and allows viewing of the wound.

SCIENTIFIC EXHIBIT
TREATMENT OF SYMPTOMS

CLINICAL MATERIAL

A ⅔ or 93 patients were women ⅓ or 47 patients were men.

B Age limit — 20-70 years with majority of patients treated in the 30-40 year bracket.

C The average length of time this group of patients was treated was 1 year. None were treated for less than 4 months. Several patients were followed and studied for 16 months.

D A complete history and a thorough physical examination including complete blood count and urinalysis, was made on each patient. Further examinations, such as egg and renal tests were made whenever indicated.

E Every patient received placebos as control. No one, including nurses and doctors, knew what was being prescribed by the dispensing clinician.

F The usual dosage for both Bellergal and the placebos was 4 tablets daily at the start of treatment. In special instances one tablet per day was administered. The dose was gradually increased until full therapeutic effect was obtained.

RECURRENT MIGRAINE AND ITS VARIANTS

RESULTS USING MEDICATION A[1]:

No. of Pts.	Excellent	Good	Poor
26	6	18	2

RESULTS USING MEDICATION B[2]:

No. of Pts.	Excellent	Good	Poor
26	0	2	24

GASTROINTESTINAL DISTURBANCES

TYPE SYMPTOMS TREATED:

a) Lump in Throat
b) "Nervous Stomach"
c) Heartburn
d) Nausea and vomiting
e) Epigastric Distress
f) Prolonged Constipation (Spastic Colon)
g) Diarrhea-Flatulence
h) Hyperacidity
i) Mucous Colitis

RESULTS USING MEDICATION A:

No. of Pts.	Excellent	Good	Poor
36	16	12	8

RESULTS USING MEDICATION B:

No. of Pts.	Excellent	Good	Poor
36	0	6	30

[1] Bellergal [2] Placebo

Presented at Indiana State Medical Association, October, 1952, by Milton L. Bankoff, V. M. Kohrman, Clinic Associates, Michigan City, Ind.

Gynecologic Disorders

TYPE SYMPTOMS TREATED:

a) Primary Dysmenorrhea
b) Painful Coitus
c) Menopausal Syndrome

RESULTS USING MEDICATION A:

No. of Pts.	Excellent	Good	Poor
38	10	16	12

RESULTS USING MEDICATION B:

No. of Pts.	Excellent	Good	Poor
38	0	4	34

CARDIOVASCULAR DISTURBANCES

TYPE SYMPTOMS TREATED:

a) Palpitation (heart consciousness)
b) Sinus Tachycardia
c) Premature Systoles
d) Left Chest Pain Without Angina
e) Blushing
f) Cardiac Arrhythmia
g) Dizziness
h) Hot Flushes
i) Neurocirculatory Asthenia
j) Precordial Pain
k) Hyperventilation
l) Respiratory Irregularity

RESULTS USING MEDICATION A:

No. of Pts.	Excellent	Good	Poor
28	14	6	8

RESULTS USING MEDICATION B:

No. of Pts.	Excellent	Good	Poor
28	1	4	23

SUMMARY OF RESULTS

TREATING NEUROVEGETATIVE DYSTONIA WITH MEDICATION A:*

	No. of Pts.	Excellent	Good	Fair	Poor	Percentage of Excellent-Good Results
1) Recurrent Migraine	26	6	18	2	0	92%
2) Gynecological Disorders	38	10	16	8	4	68%
3) Urinary Difficulties	12	2	8	1	1	83%
4) Gastrointestinal Disturbances	36	16	12	4	4	78%
5) Cardiovascular Dysfunction	28	14	6	6	2	71%
Total	140	48	60	21	11	77%

*1 TABLET OF MEDICATION A CONTAINS:
1/3 gr. - phenobarbital (central sedative)
1/600 gr. - Bellafoline (parasympathetic inhibitor)
1/210 gr. - ergotamine tartrate (sympathetic inhibitor)

TREATING NEUROVEGETATIVE DYSTONIA WITH MEDICATION B:*

	No. of Pts.	Excellent	Good	Fair	Poor	Percentage of Excellent-Good Results
1) Recurrent Migraine	26	0	2	6	18	8%
2) Gynecological Disorders	38	0	4	4	30	11%
3) Urinary Difficulties	12	0	0	5	7	0%
4) Gastrointestinal Disturbances	36	0	6	12	18	18%
5) Cardiovascular Dysfunction	28	1	4	6	17	18%
Total	140	1	16	33	90	12%

*PLACEBO: Identical in appearance, but containing only sugar.

THERAPEUTIC TRENDS

Metabolism of Intravenous Fructose and Glucose

In diabetic patients who are not receiving exogenous insulin, fructose was found to produce the same rise in pyruvic acid as it does in normal individuals. Glucose, on the other hand, effected only a slight or a delayed rise. Likewise identical were the blood disappearance curve and the urinary excretion of fructose in normal and diabetic individuals.

These results were obtained when fructose and glucose were administered intravenously in similar amounts (1 Gm. per kilogram) to five diabetic patients and seven normal subjects.

Administration of fructose was invariably followed by a fall in serum inorganic phosphorus, which change did not usually take place after the injection of glucose. The increase in blood glucose after fructose injection was higher in the diabetic patients than in the non-diabetic individuals.

Oral administration of fructose produced in one diabetic patient a much lower level of blood fructose, a smaller rise in blood pyruvic acid, a greater rise in blood glucose, and a greater glucose excretion, than did the intravenous administration of this sugar.

These observations are in agreement with the theory that the phosphorylation of fructose is uninfluenced by insulin, and therefore proceeds at a normal rate; the phosphorylation of glucose, on the other hand, is impaired in diabetes.

(Miller, M., *et al*, *J. Clin. Investig.*, 31:115, 1952.)

Antibiotic Anaphylaxis

Injection of an aqueous solution of 10 to 20 mg. (1 to 2 cc.) of the ant.-allergic drug, diphenhydramine hydrochloride, brought relief in three severe instances of drug reactions, and has since been added to 480 injections of antibiotics (administered to some 170 patients) without eliciting hypersensitivity reactions.

(Farber, J. E., and Ross, J., *Med. Times*, 80:28, 1952.)

Protein Efficiency of Breakfast Food

Some of the most used cereals have apparently the poorest biological values, according to studies made by the author. Highest rating, on the basis of protein efficiency, was found in oatmeal, Instant Ralston, and the infant foods Cerevim and Pablum.

More recently, the author discovered that whole wheat proteins could be considerably improved by the addition of the amino acid threonine, and that the protein of an infant food could be improved by the addition of minute quantities of crystalline vitamine B_{12}.

It was found that considerable improvement in the protein efficiency of this cereal could be obtained by the addition of 0.4 per cent of l-lysine monohydrocholoride, 0.2 per cent of dl-threonine, and of 0.1 ug. of crystalline vitamine B_{12}, per animal per day. This ration was still further improved by addition of an extract of fish solubles, which added 0.196 per cent of nitrogen.

(Sure, B., *Arch. Pediat.* 69:359, 1952.)

Management of Stress Incontinence

Involuntary loss of urine following a sudden increase in intra-abdominal pressure usually is evidence of loss of tone or injury of the apparatus involved in voluntary inhibition of urination. Most often, however, it is the result of a demonstrable anatomic lesion affecting the supporting structures of the urethra, bladder, and anterior vaginal wall, and dislocating their normal functional interrelationships.

The therapy is in each instance conditioned by the severity of the incontinence, the extent and nature of the anatomic lesion, and the patient's abilty to inhibit urination voluntarily.

No stereotyped procedure is practicable, but on the basis of experience gained in the treatment of some 225 patients, the following conclusions were drawn: (1) perineal exercises will afford relief in 90 per cent of patients free of anatomic lesions or afflicted only with urethrocele; (2) vaginal plastic operation of the Kelly type plus perineal exercises is best in the majority of patients with cystourethrocele and stress incontinence; the procedure will effect a cure of incontinence in 95 per cent of this group of patients; (3) surgical correction is indicated in patients with uterine prolapse and stress incontinence; (4) preliminary findings suggest that perineal muscular structures may be developed and volitional efforts initiated by means of electrical stimulation; (5) fascial sling operations give excellent results, but must be applied only in instances of intractable stress incontinence that have not yielded to less heroic measures, such as vaginal plastic procedures, perineal exercises and electrical stimulation.

(Huffman, J. W., and Sokol, J. K. *Geriatrics*, 7:2[illegible], 1952.)

Administration of Vitamin B_{12} to Newborn Infants

The results of this study suggest the conclusion that newborn infants do not generally suffer from a vitamin B_{12} deficiency.

This conclusion is based on the comparative study of the weight and height gains of twelve infants who received 5 mcg. of vitamin B_{12} daily for the first eight weeks of life, and of eleven infants who received the same dose for the first four weeks of life. It was found that the increases in weight or size of these two groups who received the vitamin supplement were not greater than the similar increases of a control group who were given a placebo.

The results seem to indicate an absence of a general deficiency of vitamin B_{12} among the infant and child population. An infant artificially fed on cows' milk receives at least as much vitamin B_{12} as a breast-fed infant, because cow's milk is richer in this vitamin.

(Chinnock, R. F., and Rosenberg, H. W., *J. Pediat.*, 40:182, 1952.)

Evaluation of Eosinophyl Counts

A study of the hourly changes in the eosinophyl count in five healthy individuals and in eight patients with arthritis revealed that the diurnal variations in this count were of sufficient magnitude to be of clinical significance, especially after the administration of certain drugs.

Solitary counts must therefore be done at the same time of each day if valid comparisons are to be drawn. The morning is considered an unsuitable time, while greater reliability can be attached to the afternoon counts. The effect of normal meals can be disregarded for the purpose of evaluating moderate or large eosinopenia.

(Swanson, J. N., Bauer, W., and Ropes, M., *Lancet* 1:129, 1952.)

Stroke

Oxygen may be given, and in cases of embolism, anti-coagulants should be administered. In cases of thrombosis or embolism blockade of the stellate ganglion is advisable; this is contra-indicated in intra-cranial hemorrhages. In hypertension and lung edema, 500 cc. of blood should be withdrawn. ½ gr. of sodium nitrite subcutaneously is also suggested in hypertension. Head and chest should be raised. Foot drop and external rotation of leg should be counteracted by foot board and sand bags. Physical therapy should start about a week after the accident. Heat treatments should be first administered, followed by electric stimulation and massage. Passive exercise should follow several days daily.

(L. Feldman. *Geriatrics*, 6:214, 1951.)

Acute Pancreatitis

The author states that medical treatment is superior to surgical treatment in acute pancreatitis. He recommends the application of novocain which diminishes the pancreatic secretion and relieves the pain immediately after injection of 20 cc. of 1% novocain solution. He states that before the treatment, a tolerance test must be carried out either hypodermically or intravenously by injection of 1 to 2 cc. From 10 to 20 cc. of 1% solution of novocain is injected intravenously 20 to 30 seconds for each cc.; the injections are repeated after three or four hours. Or an intravenous drip infusion of 1.0 Gm. in 500 cc. saline solution is given 40 to 50 drops per minute, one to three times daily. The two methods of administration may be combined by first injecting 20 cc. of 1% solution with 0.5 Gm. of ascorbic acid and then continuing with the drip.

(O. F. Longo, C. Sosa Gallorgo, *Revista Brasileira de Gastroentrelogia*, 3:627, 1951.)

Hypertension

The author reports 40 patients who were treated with hexamethonium chloride (initial doses of 125 to 250 mg. every 8 hours, increasing the daily dose until a maximum of 500 mg. every 4 hours was reached, or sustained hypertension had been converted into blood pressure showing wide fluctuations reaching normal levels) and, then, 1-hydrazinophthalazine was added (in doses of 25 to 50 mg. every 8 hours, increasing the amount daily until a dose of 100 mg. every 4 hours was reached or the blood pressure had bcome normal). "Benign" arterial hypertension was effectively controlled at normotensive or nearly normotensive levels in every case. Slight postural hypertension resulting from unsuccessful sympathectomy was enhanced. "Malignant" hypertension responded to parenteral and oral administration of the drugs in a variable way. The malignant stage was altered favorably in all but two cases. Slow reduction in blood pressure is essential to prevent serious complications. The "toxic" effects of both drugs in combination are caused by severe hypotension rapidly induced in subjects with organic vascular disease causing ischemia of brain, myocardium, or kidney.

(H. A. Schroeder, *Arch. Int. Med.*, 4:523, 1952.)

Parkinson's Disease

The authors state that a concerted regimen including chemotherapy, physical therapy and psychotherapy can effect improvement in many cases. Artane (trihexyphenidyl) was used but it was not superior to stramonium as a chemotherapeutical agent. The authors emphasize that effects attributed to chemotherapy are often the result of physical therapy and psychotherapy.

(B. Berkowitz, E. Alvermann, *Arch. Neurol. and Psychiat.*, 4:462, 1952.)

AIDS IN DIAGNOSIS

Antibiotic Synergism and Antagonism

Fixed synergistic drug combinations against specific organisms do not exist. The author found that a broad division of antibiotic agents into two groups would permit formulation of certain predictions as to their combined drug action. The two groups are as follows:

Group I: Penicillin; streptomycin; bacitracin; and neomycin.

Group II: Aureomycin; chloramphenicol; and terramycin.

Combinations of the first group he found to be frequently synergistic, occasionally indifferent, but never antagonistic. Combinations of the second group were neither synergistic nor antagonistic, but produced often simple additive effects. This effect could presumably likewise be obtained by increasing the dose of the single member. When, on the other hand, a member of group II was combined with one of group I, their combined effect depended apparently on the susceptibility of the micro-organism to the group I agent. Consequently, antagonism may be expected with a micro-organism susceptible to a group I drug, and synergism may result if the organism is resistant to a group I drug.

This scheme has proved helpful in the selection of drug combinations for the treatment of specific infections.

(Jawetz, E., *Arch. Int. Med.* 90:301, 1952.)

Blood Amino-acids

The concentrations of amino nitrogen and of several of the essential amino-acids were investigated in the blood of healthy adult human beings during fasting and following the administration of glucose or of fat. Blood samples were taken at four successive hourly intervals following a fifteen-hour fast. No significant change in amino-acid levels was elicited when no food was given during this period. When glucose was given, a highly significant fall in total amino-nitrogen level was observed; the fall was maximal at the first hour after administration. Only a very slight drop in the total amino-nitrogen level was seen in response to butter.

The blood levels of the essential amino-acids which were studied all showed a reduction after administration of glucose. It is to be noted, however, that these reductions were neither in equimolar quantities nor were they a percentage of the amount in circulation. Instead, the proportions in which the different amino-acids were affected showed a close similarity to the proportions of different essential amino-acids required by man.

These findings suggest that the administration of glucose has an immediate influence on the rate of protein synthesis. Administration of fat does not have this action.

(Munro, H. N., and Thomson, W. S. T., *Brit. J. Nutrit.* 6 (3):ii, 1952).

Hypercholesteremia and Senescence

The author states that it might appear to be an oversimplification to reach only for hypercholesteremia in treating disorders of age. However, the successful treatment of many cases with manifest arteriosclerosis has led him to the routine of determining the serum cholesterol in every patient over age 40. Whenever the level is significantly over 200 mg. per 100 cc. lipotropic medication is given in the smaller dosage as preventive measure. Author has used Methischol which contains the three lipotropic abents: methionine, inositol and choline together with liver extract and vitamin B-12 (U.S. Vitamin Corporation). Each patient was started with three capsules after each meal. After satisfactory reduction of the cholesterol level, the dosage was reduced to one capsule after each meal.

(Abrahamson, E. M., *Am. J. Digest. Dis.* 6:186, 1952.)

Trigeminal Neuralgia

The author employed a new operative procedure which was introduced by P. Taarnjoh of Denmark and G. Norlen of Sweden. It consists of decompressing the gasserian ganglion and its posterior root without dividing any of the sensory fibers of the ganglion. This new procedure prevents the frequently distressing sequelae of the division of the sensory root of the gasserian ganglion as treatment of trigeminal neuralgia: numbness of one side of the face, tongue and homolateral eye, and—if the first division of the nerve is involved—denervation of the cornea with anesthesia of this eye. The author reports on one case operated on by means of the decompression method; the effect was highly satisfactory.

(Love, J. G. *Proc. Staff Meet., Mayo Clin.*, 14:257, 1952.)

The Newborn

The baby is held horizontal with ventral surface down and the head hanging so that fluid can drain from the mouth and nose by gravity. Mouth, nose and pharynx are cleaned by aspirating with soft ear syringe. If the tongue frenulum is short it is severed with scissors after aspiration of the air passages. The cord is clamped and severed, without respect to pulsations.

If the baby is not crying vigorously by this time, the back is rubbed through the flannel blanket and oxygen is administered by a small rubber catheter connected directly to the gauge on a small tank of oxygen. The catheter is pushed back into the nasopharynx. Carbon dioxide is not administered. As soon as the baby is well oxygenated, the skin is cleaned with warm oil and a small amount of 5% sulfathiazole ointment rubbed into the skin. The baby is placed in a warm bassinet with the head down about 15 degrees. If any degree of cyanosis continues, oxygen is given by nasal catheter with a humifier interposed between catheter and oxygen gauge.

Even though the baby appears normal, 5,000 units of potassium penicillin is given intramuscularly every 3 hours prophylactically if the membranes have been ruptured for 24 hours, the amnotic fluid had an odor, the mother had intrapartum fever, the labor was prolonged. If the baby feels cold, application of external heat causes no harm. However if the baby is difficult to resuscitate and is in shock, the application of heat may be harmful. Feeding is not necessary for 12 to 24 hours. Vitamin K is administered to women in labor and to babies who are difficult to resuscitate.

(Moon, R. E., *Texas Med. J.*, 48:128, 1952.)

Coronary Thrombosis

Authors suggest administration of tromexan rather than dicumarol. On the first treatment day 1,200 mg of Tromexan are administered by mouth, followed by 900 mg. on the second day. Simultaneously heparin in doses of 10,000 units is injected intravenously, every 6 hours, within the first 1 or 2 days until the prothrombin time has been proved normal in 2 consecutive tests. Tromexan is then alone continued for 4 weeks after the beginning of the acute attack for three weeks after the last thromboembolism. On the third day the final Tromexan dose is established from daily morning determinations of the prothrombin time. Prothrombin time should be maintained 2 to 2½ times of normal level. Generally a maintenance dose of 450 to 750 mg. is appropriate.

(J. A. Tulloch, A. R. Gilchrist. *Am. Heart J.*, 42:864, 1951.)

Gout

Probenecid (benemid) was administered to 20 patients with recurrent gout or gouty arthritis. Ten of these patients were followed for periods of 5 to 7½ months. A dose of 2 gm. daily caused a fall of serum uric acid within 72 hours to an average of 55% of the control level. This was combined with an initial increase in urate excretion of 35% to 200%. Urate clearances remained increased two to fourfold with continued probenecid administration. Probenecid treatment was of greatest benefit in chronic gouty arthritis. Pain and swelling subsided and joint movement improved progressively. Although acute attacks of gout were observed in some patients after the start of the treatment, their incidence diminished with continued treatment.

(L. R. Pascale, A. Dubin, Wm. S. Hoffman, *J.A.M.A.*, 13:1188, 1952.)

for Quick Action!

in the Respiratory and Circulatory Emergencies
of Intravenous Barbiturate Anesthesia

inject **Metrazol**

1 to 3 cc. and repeat
intravenously, intramuscularly, subcutaneously

collapse following accidents · surgical trauma
opiate and barbiturate depression · asphyxia
· denarcotization after general anesthesia ·

COUNCIL ACCEPTED

Ampules 1 and 3 cc., tablets, solution, powder

Metrazol, brand of pentamethylentetrazol, Trade Mark, reg. U. S. Pat. Off.

BILHUBER-KNOLL CORP. ORANGE, NEW JERSEY

FREE LITERATURE SERVICE

Arrangements have been made to forward you the most recent literature available on the conditions listed below. Please indicate on the yellow self-mailer the information you desire by circling the appropriate number.

Allergies

allergic reactions 1; asthma 2; asthma, bronchial 3; drug sensitivities 4; hay fever 5; urticaria 6.

Cardiovascular

arteriosclerotic peripheral vascular disease 7; cardiovascular disorders 8; heart disease 9; hypertension 10; myocardial failure 11; myocardial insufficiency 12; peripheral neuritis 13; Raynaud's disease 14; thromboangiitis obliterans 15; varicose veins 16.

Dermatology

acne 17; bacterial dermatologic conditions 18; bed sores 19; dermatitis 20; diaper dermatitis 21; dermatosis 22; eczema 23; fungus diseases 24; pruritus 25; pruritus, associated with dermatitis and ulceration 26; topical infections 27; yaws 28.

Endocrinology

adrenal gland, diseases of 29; exophthalmic goiter 30; Graves' disease 31; hyperthyroidism 32; pituitary gland 33; thyroid gland 34; thyrotoxicosis 35.

Eye, Ear, Nose and Throat

choroiditis 36; eye infections 37; iritis 38; keratitis 39; night blindness 40; sympathetic ophthalmia 41; uveitis 42; ear, infections 43; otologic dermatosis 44; vasomotor rhinitis 45.

Gastro-Intestinal

amebiasis 46; colitis 47; constipation, chronic 48; constipation, geriatric 49; constipation, infant 50; peptic ulcer 51.

Genito-Urinary

bladder, diseases of 52; cystitis 53; kidney, diseases of 54; prostate gland 55; pyelitis 56; ureter, diseases of 57; urethra, diseases of 58.

Geriatrics

climacteric, male 59; senility, female 60; senility, male 61.

Gynecology and Obstetrics

amenorrhea 62; cervicitis 63; climacteric, female 64; disorders of menstruation 65; dysmenorrhea 66; female disorders 67; leukoplakia vulvar 68; leukorrhea 69; menometrorrhagia 70; postpartum bleeding 71; lactation 72; pre-

menstrual tension 73; Trichomonas vaginalis 74; vaginitis 75.

Neuromuscular

analgesic 76; joint and muscle pain 77; muscle dysfunctions 78; muscle spasm 79; multiple sclerosis 80; neuralgia ischiatica 81; neuritis, diabetic 82; osseous and neuromuscular disturbances 83; Parkinsonism 84.

Nutrition

anemia 85; avitaminoses 86; impaired fat metabolism 87; malnutrition 88; mineral deficiencies 89; obesity 90; multivitamin deficiencies 91; pellagra 92; protein deficiency 93; vitamin deficiencies 94; multiple deficiencies 95.

Psychoneuroses

alcoholism 96; insomnia 97; neuropsychiatry 98; psychoses 99.

Respiratory Tract

bronchitis 100; common cold 101; cough 102; laryngitis 103.

Rheumatic and Arthritic Diseases

bursitis 104; gout 105; gouty arthritis 106; rheumatic disease 107; rheumatic fever 108; rheumatoid arthritis 109; Still's disease 110.

Miscellaneous

barbiturate poisoning 111; debridement of necrotic tissue 112; edema 113; edema, salt retention 114.

FOR THE FIRST TIME!

Automatic Spray Topical Anesthetic

FOR OFFICE USE

Now, just press the button and spray on quick relief from surface pain and itching—with new Americaine AEROSOL—automatic spray topical anesthetic. Also bacteriostatic and water-soluble. For wounds, burns, eczemas, post-episiotomies, post-removal of tape, etc. Invaluable in debridement of wounds. Order by mail. **$4.25**
11-oz. size, physician's price, postpaid, only.....

***Americaine* AEROSOL**
Automatic Spray Topical Anesthetic
Containing 20% Dissolved Benzocaine

A New Convenience in Topical Anesthetics

★ Painless and easy to apply
★ Quick to cover extensive areas
★ Sanitary — No spatulas, swabs, or manual applicators

USE HANDY COUPON TO ORDER
Return for refund if not satisfied

ARNAR-STONE LABORATORIES, INC.
1316-C Sherman Ave., Evanston, Ill.
Please send ____ Americaine Aerosol Automatic Spray Topical Anesthetic. I enclose $_____
Name_____
Address_____
City_____ Zone____ State_____

Fuchsonium Compound for Non-specific Cervicitis and Vaginal Thrush

Gentian violet has generally proved the most effective remedy for the treatment of that large number of patients with vaginal discharge, which is not caused by a gross organic lesion and from which no definite pathogen can be isolated.

Unfortunately, this remedial agent suffers from the disadvantage that it stains hands, clothing and bed-linen, and sometimes causes severe irritation and even "burning' of the tissues.

A search was therefore made for a preparation which would be as effective as gentian violet without having its disadvantages. The substance which was found to qualify in these respects is a sulphonated derivative of fuchsonium and of sodium biborate.

The preparation has thus far been successfully applied to 80 patients with non-specific cervicitis and to 60 patients with vaginal thrush. The product is made into a cream and dispensed from a tube by means of a patent plastic applicator. Tube and applicator are supplied to the patients after careful instruction in their use by the clinician. The cream is applied nightly. Applications can also be made by means of pessaries.

Seventy of the eighty patients with non-specific cervicitis treated with this preparation obtained rapid relief of subjective symptoms, with disappearance of pruritus and irritation, after two applications. The discharge persisted for a somewhat longer period, but 61 patients were subsequently cured completely with cessation of the discharge and all associated symptoms. Some failures occurred in the earlier series of patients when treatment was applied only twice a week. But all of these cases responded satisfactorily (except one patient with trichomonads in the discharge) when the treatment was given daily.

The average number of applications in the patients who responded initially was 4.5; in the cases requiring more vigorous treatment the number of applications was nine. The over-all results obtained in this series of eighty patients was 83.7 per cent "cured," and 11 per cent "much improved."

The group of sixty patients afflicted with vaginal thrush was treated in a manner identical with that described above. The results were particularly striking, for relief was obtained almost instantaneously. All signs and symptoms disappeared within seven to ten days. It should be noted, however, that in spite of this prompt relief the gram-positive yeast buds could still be demonstrated for some days after all discharge had ceased. But all signs of inflammation and the discharge disappeared after four or five applications, and without a single failure. This new preparation thus offers definite advantages over gentian violet.

(Hart,D. McK., and Brown, C. H., *Brit. Med. J.* 2:813, 1952.)